(c) An M+C organization that operates an M+C plan through subcontracted physician groups or other subcontracted networks of health care professionals must provide that the participation procedures in this section apply equally to physicians and other health care professionals within those subcontracted groups.

§ 422.204 Provider credentialing and provider rights.

(a) *Basic requirements.* An M+C organization must follow a documented process with respect to providers and suppliers who have signed contracts or participation agreements that—

(1) For providers (other than physicians and other health care professionals) requires determination, and redetermination at specified intervals, that each provider—

(i) Licensed to operate in the State, and in compliance with any other applicable State or Federal requirements; and

(ii) Reviewed and approved by an accrediting body, or meets the standards established by the organization itself;

(2) For physicians and other health care professionals, including members of physician groups, covers—

(i) Initial credentialing that includes written application, verification of licensure and other information from primary sources, disciplinary status, eligibility for payment under Medicare, and site visits as appropriate. The application must be signed and dated and include an attestation by the applicant of the correctness and completeness of the application and other information submitted in support of the application;

(ii) Recredentialing at least every 2 years that updates information obtained during initial credentialing and considers performance indicators such as those collected through quality assurance programs, utilization management systems, handling of grievances and appeals, enrollee satisfaction surveys, and other plan activities, and that includes an attestation of the correctness and completeness of the new information; and

(iii) A process for receiving advice from contracting health care professionals with respect to criteria for credentialing and recredentialing; and

(iv) Requiring that, to the extent applicable, the requirements in paragraphs (a)(2)(i) and (a)(2)(iii) of this section are satisfied; and

(3)(i) Specify that basic benefits must be provided through, or payments must be made to, providers that meet applicable requirements of title XVIII and part A of title XI of the Act. In the case of providers meeting the definition of ''provider of services'' in section 1861(u), basic benefits may only be provided through such providers if they have a provider agreement with HCFA permitting them to provide services under original Medicare.

(ii) Ensures compliance with the requirements at §422.752(a)(8) that prohibit employment or contracts with individuals (or with an entity that employs or contracts with such an individual) excluded from participation under Medicare and with the requirements at §422.220 regarding physicians and practitioners who opt out of Medicare.

(b) *Discrimination prohibited*—(1) *General rule.* An M+C organization may not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his or her license or certification under State law, solely on the basis of the license or certification.

(2) *Construction.* The prohibition in paragraph (b)(1) of this section does not preclude any of the following by the M+C organization:

(i) Refusal to grant participation to health care professionals in excess of the number necessary to meet the needs of the plan's enrollees (except for M+C private-fee-for-service plans, which may not refuse to contract on this basis).

(ii) Use of different reimbursement amounts for different specialties.

(iii) Implementation of measures designed to maintain quality and control costs consistent with its responsibilities.

(c) *Denial, suspension, or termination of contract.* The requirements in this paragraph (c) apply to an M+C organization that operates a coordinated care

plan or network MSA plan providing benefits through contracting providers.

(1) *Notice to health care professional.* An M+C organization that denies, suspends, or terminates an agreement under which the health care professional provides services to M+C plan enrollees must give the affected individual written notice of the following:

(i) The reasons for the action.

(ii) The standards and the profiling data the organization used to evaluate the health care professional.

(iii) The numbers and mix of health care professionals the organization needs.

(iv) The affected health care professional's right to appeal the action and the process and timing for requesting a hearing.

(2) *Composition of hearing panel.* The M+C organization must ensure that the majority of the hearing panel members are peers of the affected health care professional.

(3) *Notice to licensing or disciplinary bodies.* An M+C organization that suspends or terminates a contract with a health care professional because of deficiencies in the quality of care must give written notice of that action to licensing or disciplinary bodies or to other appropriate authorities.

(4) *Timeframes.* An M+C organization and a contracting provider must provide at least 60 days written notice to each other before terminating the contract without cause.

§ 422.206 Interference with health care professionals' advice to enrollees prohibited.

(a) *General rule.* (1) An M+C organization may not prohibit or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising, or advocating on behalf of, an individual who is a patient and enrolled under an M+C plan about—

(i) The patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to the individual to provide an opportunity to decide among all relevant treatment options;

(ii) The risks, benefits, and consequences of treatment or non-treatment; or

(iii) The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

(2) Health care professionals must provide information regarding treatment options in a culturally-competent manner, including the option of no treatment. Health care professionals must ensure that individuals with disabilities have effective communications with participants throughout the health system in making decisions regarding treatment options.

(b) *Conscience protection.* The general rule in paragraph (a) of this section does not require the M+C plan to cover, furnish, or pay for a particular counseling or referral service if the M+C organization that offers the plan—

(1) Objects to the provision of that service on moral or religious grounds; and

(2) Through appropriate written means, makes available information on these policies as follows:

(i) To HCFA, with its application for a Medicare contract, or within 10 days of submitting its ACR proposal, as appropriate.

(ii) To prospective enrollees, before or during enrollment.

(iii) With respect to current enrollees, the organization is eligible for the exception provided in paragraph (a)(1) of this section if it provides notice within 90 days after adopting the policy at issue; however, under § 422.111(d), notice of such a change must be given in advance.

(c) *Construction.* Nothing in paragraph (b) of this section may be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974.

(d) *Sanctions.* An M+C organization that violates the prohibition of paragraph (a) of this section or the conditions in paragraph (b) of this section is subject to intermediate sanctions under subpart O of this part.